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HIV Stigma Policy in China and Thailand at the turn of 2020s

Topic and Research Question

Research Question: *"Does the HIV Stigma Legal Framework in China and Thailand at the turn of the 2020s Comply with the International Standards, and What Can China Learn from Thailand's Case about Addressing HIV Stigma in Healthcare Settings?"*. Key populations are at the centre of the UNAIDS *Global AIDS Strategy 2021-2026*, and stigma and discrimination are named the central structural barrier for key populations to access HIV services. Tackling HIV stigma in legal and healthcare settings would contribute to the success of the HIV services outreach (95-95-95 indicators), Treatment as a Prevention approach to addressing HIV, and to the achievement of the 2030 Sustainable Development Goals (#3,4,5,8,10 and 16). East Asia and the Pacific stays UNAIDS priority region, where Thailand is one of the global best examples of successful state efforts to address HIV stigma.

State of the Art

HIV stigma is a "complex problem requiring complex solutions" (Stangl et al. 2013, 11) among other things because their studies and results "fail to embed within theoretical frameworks" for reasons not yet established (Pantelic, Sprague, and Stangl 2019, 5; Phelan et al. 2014, 17). This field of study also falls into the trap of the "Dodo bird effect" (Corrigan and Fong 2014, 110).

The concept of ***stigma*** developed by Erving Goffman ([1963] 1990, 12) was defined as "an attribute that is deeply discrediting [an individual that possesses it]". ***Structural stigma*** is "societal-level conditions, cultural norms, and institutional policies constraining the opportunities, resources, and wellbeing of stigmatized" (Hatzenbuehler and Link 2014, 2) operationalized through government and private institutions' rules and regulations (Corrigan et al. 2005, 562), attitudes, social policies, status, and culture (Hatzenbuehler and Link 2014, 5), or lack of policies protecting the rights of vulnerable groups (Hatzenbuehler, Keyes, and Hasin 2009, 2275). Structural stigma research is based on the *Ecological model for health promotion* by McLeroy et al. (1988, 355) which helped shift the focus from intrapersonal to structural factors of human health.

Research claims that individual-level stigma is more a mediator between the social situation or discriminatory social structures and norms (and other manifestations of the structural stigma) and their negative outcomes than a direct cause of its negative outcomes or impacts. First and foremost, **structural HIV stigma** should be addressed by changing the power imbalance between the stigmatizers and the stigmatized ones (Link and Phelan 2014, 31). Besides, individual-level health interventions, e.g., "educating" people about making good health choices, sometimes operate in the victim-blaming logic (Pantelic, Sprague, and Stangl 2019, 4) and should always be accompanied by changes in public policy. Another priority is addressing **stigma enacted in healthcare settings,** as it leads to a greater internalization of the stigmatizing views and self-silence which would mediate deficient access to treatment (Ungar, Knaak, and Szeto 2016, 263; Srithanaviboonchai, Stockton, et al. 2017, 1).

Methodology and Approach

HIV stigma and discrimination embody the human-rights-related barriers to health and addressing the HIV epidemic. E.g., the structural stigma is operationalized through punitive laws and regulations which limit an individual's rights to health or non-discrimination and are a barrier to effectively addressing HIV. Hence, a **human rights-based approach** is well established in addressing the HIV stigma.

Existing stigma indicators are based on quantitative surveys and qualitative interviews, which can only measure the individual but not structural manifestations of stigma, so human rights indicators were used as measurement units in this analytical framework. The UN OHCHR *Human Rights Indicators Guide* divides the indicators for measuring human rights into three main categories: ***structural indicators*** – those focusing on the state's legal and policy frameworks' *status quo* and the government's policy statement regarding the specific right in question, ***process indicators*** – those aiming to quantify the state's endeavours to translate their human rights duties into the desired outcomes, and ***outcome indicators*** – those "reflecting the state of enjoyment of human rights in a given context" (2013, 35–37).

The first criterion, *HIV Stigma Legal Framework*, aims to address the first part of the research question and consists of structural HRIs. Punitive and protective laws and regulations are the objects of this criterion's review. The second criterion, *HIV Stigma Policy Framework in Healthcare Settings and its Implementation*, aims to solve the second part of the research question, and uses both structural and process indicators to access the relevant policies and their implementation. The third criterion, *HIV Stigma Policy Outcomes*, helps compare the outcomes of these policies and uses the outcome indicators for that purpose. The Analytical Framework is presented below.

Criteria	Sub-criteria
HIV Stigma Legal Framework	Laws and Regulations on the Right to Health
	Laws and Regulations on the Right to Non-Discrimination
	Punitive Laws and Regulations
HIV Stigma Policy Framework in Healthcare Settings and its Implementation	Policies and Regulations Relevant to Addressing Stigma in Healthcare Settings
	Implementation of the Policies and Regulations Relevant to Addressing Stigma in Healthcare Settings
HIV Stigma Policy Outcomes	Key Populations Stigma and Discrimination
	Key Populations Stigma and Discrimination in Healthcare Settings
	HIV Policy Outcomes

Main Facts

11 out of 14 reviewed regulations are enabling in Thailand, and only 5 in China. In terms of the laws protecting the rights to health and non-discrimination, Thailand is also significantly ahead of China having ratified more international human rights conventions and better and more consistently reflected the human rights obligations in Constitution and national law.

Thailand scores much better in most of the stigma and discrimination levels indicators. In both countries, 22% of those whose rights were violated in work settings have sought redress, but in Thailand over half were satisfied with the results, while only 16% were satisfied in China. Stigma and discrimination levels are particularly strongly decreasing in healthcare settings in Thailand: they have decreased by 30-50% for different groups between 2014-15 and 2020-21. In China, there is no longitudinal and directly comparable data for any of the stigma level indicators, but overall S&D levels against the key populations are much higher than in Thailand. Some data is presented in the table below.

Indicator	Thailand (in the last 12 months)	China (in a lifetime)
PLWH facing stigma in healthcare	11.1% (2017)	49% (2017)
MSM avoiding healthcare due to stigma	5.6% (2018)	40% (2017)
PLWH personal data being leaked	10.3% (2017)	18% (2017)
PLWH being refused treatment	(8% for PWID)	24% (2017)
HCWs provided differential treatment	20.7% - 27% (2017)	51% (2017)
HCWs unwilling to care for HIV+ patients	11.4% (2017)	65.2% (2020)
HCWs afraid of contracting HIV	42.6% (2021)	79.2% (2021)

Results

Chinese HIV stigma legal framework is characterized as a rather punitive one and Thailand's legal framework is characterized as a rather enabling one and much closer to the international standards set by the international human rights conventions and UNAIDS recommendations, than China's**,** although both countries have some for improvement. Thailand acknowledges S&D as one of the three key challenges and commits to using human rights approach and reducing inequalities when addressing HIV. China does not, and places the responsibility for contracting HIV on individuals, e.g., sex workers and drug users engaging in "public misconduct" and "illegal activities"; policy documents also employ a lot of combatant language.

China can use Thailand's 3x4 programme to complement some of the structural interventions to address the HIV stigma that it already has in place. Thailand, using the best international experience, has developed its own system for measuring S&D in healthcare settings, and its 3x4 programme addresses it via a series of individual, institutional, and community interventions. The trainings for HCWs lie at the centre of this programme and fit all the criteria: they are participation-based, involve contact with key populations, and cover a wide range of topics from human rights to confidentiality protection.

Although Thailand's performance was better in almost all the structural and outcome human rights indicators related to HIV stigma, **China still has demonstrated better results in some of the HIV policy outcome indicators**, which can be explained by other factors than HIV stigma policy, e.g., by a significantly more severe history of the HIV epidemic in Thailand.

References

All references can be found at http://bitly.ws/vPVw

About the Author

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